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CONTENTS.

CLINICAL LECTURES.

On Chronic Cystitis and its Treatment by Injections of Strong Solutions of Nitrate of Silver. By T. G. Richardson, M.D., Professor of Surgery in the Medical Department of the University of Louisiana . 85

Summer Prurigo; Prurigo Æstivalis, seu Pruri go Adolescentium, seu Acne Prurigo. By Jonathan Hutchinson, F.R.C.S., Senior Surgeon to the London Hospital and to the Hospital for the Diseases of the Skin, etc. 95

HOSPITAL NOTES AND GLEANINGS.

Menstrual Fluid retained in the Left Fallopian Tube, Similating Ovarian Tumour; Abdominal Section during Acute Peritonitis 98

Fracture of the Humerus by Direct Muscular Action (Throwing a Cricket-Ball), no Displacement 99

MEDICAL NEWS.

Domestic Intelligence—Treatment of Typhoid Fever 99

Medical and Chirurgical Faculty of Maryland 101

South Carolina State Medical Association . 101

Georgia Medical Association . . . 101

Florida State Medical Association . . 101

Alabama State Medical Association . . 102

Mississippi State Medical Association . 102

Texas State Medical Association . . 102

Tennessee State Medical Society . . 103

Michigan State Medical Society . . . 102

California State Medical Society . . . 102

Illinois State Board of Health . . . 103

Metric System of Weights and Measures . 103

Foreign Intelligence—Cure of Chronic Albuminuria by Fuchsine 103

Marino's Antineuralgic Injection . . 103

The Treatment of Cancer by Pressure . 103

Inflammation of the Bladder . . . 104

Ointment in Gonorrhœal Orchitis . . 105

Arterial Degeneration and Vegetable Diet 105

Sewer-Communications and Filth-Diseases 105

Treatment of Wounds of the Hand . . 107

GOSSELIN'S CLINICAL LECTURES ON SURGERY . . . . 8 PAGES.

CLINICAL LECTURES.

ON CHRONIC CYSTITIS AND ITS TREATMENT BY INJECTIONS OF STRONG SOLUTIONS OF NITRATE OF SILVER.

BY T. G. RICHARDSON, M.D.,

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Delivered at the Charity Hospital, New Orleans.

GENTLEMEN: Those of you who have accompanied me through the surgical wards during the past few weeks have had the opportunity of seeing a number of cases of chronic cystitis, and of witnessing the results of the remedial measures employed in each. Without entering into the details of the histories of these cases, I propose, this morning, to use them as a text for a few remarks upon the disease in general, and its management.

Chronic cystitis, as you have already learned by observation, is by no means an uncommon malady, and is in this respect in marked contrast with the acute form, which is comparatively rare. It is far more frequently seen in the male than in the female, although some of the most intractable cases which have come into my hands have been in the latter sex. Except when associated in children with calculus, or some other foreign substance in the cavity of the bladder, it is almost

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altogether a disease of adult life. Its seat is the mucous membrane of the bladder, from which it may extend to the other tissues of the organ, and along the lining of the ureters to the pelves and uriniferous tubules of the kidneys.

The *Causes* of chronic cystitis are very various, and as they determine in a large proportion of cases the mode of treatment which should be employed, I must call your attention to those most commonly observed.

1. Chronic cystitis may be a sequel of acute inflammation.

2. Notwithstanding the fact that the mucous membrane of the bladder is constantly in contact with a fluid which in relation to most of the tissues of the body is a decided irritant, the presence of a calculus or other foreign substance is resented with almost as much commotion as the entrance of a strange insect into a hive of bees; and, as in the latter instance, reconciliation is impossible so long as the intruder remains within the hive, so in the former the excitement continues until the offending substance is removed or expelled, and sometimes even for an indefinite time thereafter. It matters not that the stone enters quietly through the ureter in the form of a minute gravel, and attains its growth by slow degrees, or, as is sometimes the case, that it is so smooth as to glide about from one corner to another without appreciable friction; the organ rarely if ever consents quietly to its stay. You may readily imagine how much greater the disturbance produced when the offender is a rough prickly concretion of oxalate of lime, such as I show you here, or the jointed vertebræ of a squirrel's tail (introduced from without, of course), partially incrusted by phosphatic deposits, as you see in this other specimen. In certain localities, as, for instance, the State of Tennessee and the adjacent parts of the contiguous States, calculus is probably the most common cause of chronic cystitis, but elsewhere in this country it occupies a subordinate place.

3. Undoubtedly the most universal cause of the disease in question is obstruction to the complete evacuation of the bladder. This may result from stricture of the urethra, hypertrophy of the prostate, transverse bar at the neck of the bladder, lodgment of calculus or other foreign body in the urethra, etc. etc. In the first two of these conditions there is an additional liability arising from an extension of inflammation from the stricture or the enlarged prostate. The manner in which obstruction leads to inflammation requires a little explanation.

There is in health always more or less mucus in the urine, arising from the natural action of the lining membrane of the bladder, but the quantity is so small as to pass unnoticed in ordinary examinations. Nevertheless, it may sometimes be detected by allowing the fluid to stand for a few hours in a test tube, when it will be found to have settled in a slight cloud at the bottom. Where obstruction exists the protracted and violent effort to empty the bladder induces an increased secretion of mucus, which gravitates to the base of the organ. Now, bear in mind that the trigone in the male after middle life is a little below the level of the orifice of the neck of the organ, and is nearly fixed in its position, so that during micturition it *does not participate in the general contraction of the walls.* Any mucus having settled here is very likely, therefore, to remain in place after micturition, more especially as patients labouring under obstruction generally stop short of the complete performance of this function from the fatigue and pain which the effort induces. The mucus which thus collects in the basin of the *bas fond* undergoes decomposition, and having thereby become acrid and irritating awakens inflammation of the mucous membrane already in a state of excitement and active congestion from the frequent and violent endeavours of the individual to relieve himself. Inflammation having been lighted up, pus is added to the mucus already largely increased in quantity from the same cause, and thus by the supply of more material the putrefactive processes are rendered more vigorous, and their products more abundant and irritating.

4. Injuries of the spine producing complete or only partial paralysis are almost

invariably followed by chronic cystitis. Not unfrequently the immediate cause of the inflammation in these cases is the injury inflicted upon the bladder by the overstretching of its walls from the retention of urine which results from such accidents. But even in cases where the medical attendant is upon his guard, and takes the precaution to draw off the urine by means of a catheter, and repeat this operation at proper intervals, evidences of morbid action are almost certain to appear within two or three days. The explanation may possibly be found in the passive congestion of the mucous membrane arising from loss of nerve power, and the impracticability of emptying the bladder by ordinary catheterism when its walls are in a flaccid condition. Under other circumstances, that is to say, when no paralysis exists, the withdrawal of the urine by the catheter is attended by contraction of the vesical walls, by which means all the fluid is expelled from the cavity. But, on the contrary, in such cases as we are now considering, and of which you have a marked example in ward 6, the urine being forced out by the pressure of the abdominal viscera and the temporary contraction of the abdominal muscles, the walls of the organ are crowded in upon themselves forming irregular folds between which more or less urine is always retained. The mucus which is, of course, largely increased in quantity by the atonic congestion, settles to the bottom whence it is only partially removed by the catheter, the remainder undergoing putrefactive decomposition which, by its reaction, increases the inflammatory action, as in the previous case.

5. Excessive alkalinity or acidity of the urine are said to produce chronic cystitis, but I am inclined to think that in such cases the morbid action is due principally to the deposition of the solid constituents of the fluid, rather than to the chemical effect of the latter upon the mucous membrane. This membrane being physiologically proof against harm from the varying qualities of the urine within the range of health, will often bear without resentment the contact of fluids of a tolerably pungent or acrid quality, while, on the contrary, as I have already stated, it rebels instantly and continuously against the lodgment of any solid substance, however simple, within its walls. From my own experience, I am led to believe that a close examination of the urine—or rather of the urinal—in such cases will always disclose sedimentary deposits in greater or less abundance. This is particularly true in reference to urine which is excessively alkaline, in which phosphatic deposits in the form of minute seed-like concretions sometimes occur, and become the cause of inflammatory excitement. These alkaline deposits are, doubtless, very often the *result* of the inflammation rather than the *cause*, and it is no easy matter always to distinguish between the two.

Morbid Anatomy. — The structural changes induced by chronic cystitis consist primarily in thickening and increased vascularity of the mucous membrane, in which, however, there is nothing peculiar, inasmuch as the same takes place in nearly all other similar membranes when invaded by chronic inflammation. The mucous follicles are, of course, much enlarged, and secrete, sometimes, a wonderful amount of viscid ropy mucus.

The most striking alteration, however, is seen in the muscular tunic, which in all cases of long standing is more or less hypertrophied, and projects into the cavity of the organ in the form of a very coarse netting, in the interstices of which the mucous membrane is depressed, forming shallow crypts or lacunæ, of various sizes, from that of a hempseed to that of a filbert. In very bad cases, the greatly thickened muscular bundles look not unlike the *columnæ carneæ* of the cardiac ventricles, and are characteristic of what some surgeons term columnar vesical hypertrophy. Under these circumstances the cavity of the organ is greatly reduced in its capacity, sometimes to such a degree, as you have seen in the case of the patient in ward 14, that it can contain only an ounce of urine, or even less. The walls themselves frequently measure an inch in thickness, as in the specimen I show you here. Associated with this remarkable hypertrophy of the muscular coat, we not unfrequently observe that the

little shallow crypts formed in the interstices of the muscular bundles become very much deeper, and, in some instances, form hernia-like protrusions upon the outer face of the bladder, varying in diameter from that of a pea to that of a pullet's egg. When these become quite large the organ is said to be sacculated. Occasionally, one of these so-called herniæ will continue to enlarge until its capacity equals, or even surpasses, that of the bladder, with which it communicates by a comparatively small opening. An illustration of this is seen in the specimen upon the dish before you, which is, to all appearances, a double bladder, the two compartments communicating through an aperture not larger than a No. 7 or 8 catheter. I know nothing of the history of the case from which this interesting specimen was taken, save that the patient, a poor, simple-minded, emaciated, old countryman, entered the hospital for general debility, presenting also a urinary fistula leading from the umbilicus along the line of the urachus to the fundus of the bladder; and that he died within a very few days afterward, before any satisfactory history could be obtained.

This hypertrophied condition of the muscular coat of which we are speaking is readily explained in most cases by the frequent and violent contractions of the bladder in its efforts to overcome a persistent obstruction to the exit of the urine. But it is not limited to such cases, for it is sometimes met with in chronic cystitis where no obstacle exists. This is well illustrated in the patient already referred to in ward 14, in whom, so far as I can ascertain, no difficulty in emptying the organ has ever existed, and in whom a No. 12 bougie may be readily passed. In this and other similar instances violent spasmodic contractions are of frequent occurrence daily in consequence of the excessive sensibility of the inflamed mucous membrane, and in the course of time give rise to the same condition of muscular hypertrophy as in the former cases.

In connection with these pathological conditions of the bladder itself, I must not neglect to call your attention for one moment at least to the serious changes which sometimes take place in the ureters and kidneys in consequence of an extension of the inflammation in this direction. Such extension is by no means rare, and commonly results not only in great thickening and induration of the walls of the ureters, but destructive ulceration and abscess of the kidneys. This is more particularly the case where the inflammation is caused and maintained by protracted obstruction to the discharge of the urine from the bladder.

Before leaving this branch of the subject, permit me to impress upon your minds the importance of a knowledge of the morbid changes upon which I have been descanting. Upon their existence or non-existence in any given case will depend to a large extent its curability or incurability.

The *Symptoms* usually presented by chronic cystitis are so well marked as to render its detection tolerably easy; but owing to the fact that the affection is sometimes simulated in hysteria, and at other times masked by concurrent diseases of the adjoining organs, it is desirable always to obtain as accurate a history of each case as possible. Without this, indeed, it is scarce y possible to appreciate the different phases which it assumes in consequence of the differences in the causes by which it is produced. The two immediate signs, however, upon which we mainly rely are, 1st, inability of the patient to retain his water longer than a few minutes, or, at most, an hour or two; 2d, the presence of tenacious mucus, mixed with more or less pus, in the urine; and, 3d, vesical tenesmus.

The first of these evidences, that is to say, the pressing and frequently recurring desire to empty the bladder, is often observed in other conditions, such as irritation at the neck of the bladder from gleet, from the lodgment of gravel in the prostatic urethra, from mental anxiety, from a morbid state of the urine, from the presence of ascarides in the rectum, from vaginitis, cervicitis, and other inflammatory states of the adjacent organs of the female, and from numerous other causes which I need not here mention. On the other hand, it may be almost entirely

wanting, of which I have just now a most remarkable instance in a private patient who, although for a long time a subject of the disease, has always been able to carry his water five or six hours without special inconvenience. Nevertheless the symptom is an important one, and should be carefully investigated.

The appearance of thick viscid mucus in the urine is almost pathognomonic of chronic cystitis. It is usually quite abundant, almost transparent, except when mixed with pus, and so tenacious that it clings to the bottom of the vessel in long stringy masses while the urine is poured off, and then, if the vessel is smooth, suddenly slips away like a mass of half-coagulated jelly. The quantity of this secretion is sometimes very great, and in such cases the disease is frequently denominated *vesical catarrh*, a term which it seems to me is entirely unnecessary, and likely to mislead the student. As mucus of this description in the urine can come only from the lining membrane of the bladder, and is necessarily the result of chronic inflammation, you see very clearly how important it is in a diagnostic point of view. And here I take the opportunity of saying that *when this secretion is wanting true chronic cystitis does not exist.* In making this assertion I am well aware that I run counter to the opinions of many excellent surgeons who, under the abominable term of *irritable bladder*, recognize a species of chronic inflammation in which little or none of the usual glutinous mucus is secreted; but I can scarcely do otherwise, inasmuch as I have never seen and can scarcely imagine such a case. The morbid condition to which this name has been applied may be one of chronic inflammation of the lining membrane of the neck of the bladder, extending, possibly, a very little way into the body of the organ; but, to my mind, this is quite as distinct from chronic cystitis as chronic laryngitis is from chronic bronchitis. But in the majority of cases the irritable bladder is no disease at all, but only a symptom of trouble elsewhere; it may be in the nervous system, in the rectum, in the kidneys, or in the urethra.

As already stated, there is very commonly mixed with the mucus more or less pus, which settles to the bottom along with the latter, as you see well exhibited in this glass, the contents of which were passed by the patient in ward 8. Oftentimes the pus is so abundant as to conceal the mucus from view until the supernatant fluid is poured off, when the ropiness of the latter readily discloses its presence.

Large quantities of phosphates are not unfrequently observed in the mucus to which they impart a whitish slimy appearance, not unlike that of thin mortar. When this is the case, the urine is, of course, strongly alkaline, and gives off a powerful ammoniacal smell.

The vesical tenesmus which has been mentioned as an accompaniment of chronic cystitis is not characteristic, but often a most distressing symptom, seizing the patient suddenly, and not relaxing its painful grip until the last drop of water is expelled. It well deserves to be called *vesical cramp;* and when it occurs repeatedly every day for a great length of time is sure to result in hypertrophy of the muscular coat, of which it then becomes an important symptom.

The general health is not necessarily seriously impaired by chronic cystitis, unless the disease is associated with other morbid conditions, or is attended with constantly recurring tenesmus. In the latter case the system may give way in consequence of the suffering, especially in the case of old men with enlarged prostate. On the contrary, the worst case of this disease which I have ever encountered, a case in which the patient is unable to retain his urine longer than five or six minutes, and in whom tenesmus occurs many times during the day, is that of a man in middle life whose general health continues most excellent now after six or eight years of suffering.

Diagnosis.—Bearing in mind the symptoms which have just been detailed, you can scarcely err in determining the presence of chronic inflammation of the bladder; but it is not always so easy to discover its cause. As without a knowledge of the latter it is impossible to pronounce a rational prognosis or institute suitable treatment, it is of the first importance

that this question should be satisfactorily settled. For this purpose the history of the case should be accurately ascertained. If the disease succeeded to an injury of the spine, resulting in paralysis of the lower half of the body, there can be no doubt that the accident was the essential cause. If it was immediately preceded by gleet, the probability is that it was induced by an extension of inflammation from the latter, and is kept up by stricture of the urethra, and consequent inability to empty the bladder entirely. The urethra should be examined with a bougie under such circumstances in order to ascertain whether such is the case. If no stricture should be found, the examination should extend to the bladder itself, and thorough search made to determine whether calculus does not exist. If the patient is an old man, who relates that he has had great difficulty in emptying the bladder for several years, and that of late stringy mucus has made its appearance, the natural suspicion is that a hypertrophied prostate is the source of the trouble. This can be determined, of course, by the finger in the rectum, and a metallic bougie in the bladder. Not very unfrequently calculus and enlarged prostate coexist. None of these causes having been discovered, attention should be directed to the condition of the urine, for, as already stated, it occasionally happens that excessive acidity or, more frequently, excessive alkalinity may give rise to the disease. Without dwelling longer upon this point, permit me to say that in nearly all cases of chronic cystitis careful exploration of the bladder and urethra by means of a metallic bougie is necessary. Even though no calculus, stricture, or enlarged prostate should be detected, valuable information is obtained as to the condition of the mucous membrane, and a hitherto unsuspected tumour of the bladder may be detected. It is also equally incumbent upon the surgeon to examine the urine, for aside from the effect which may be produced upon the bladder by morbid states of this fluid, it is by this means alone that we are enabled to ascertain whether the kidneys have become implicated in the inflammation. Extension of the morbid action to these organs by way of the ureters is, unfortunately, not a very rare occurrence; and, when such is the case, there can be but little expectation of permanent benefit by treatment. If albumen should be present in large quantities, there can be scarcely a doubt as to the existence of this serious complication; much less if great numbers of tubular casts should be discovered by the microscope. On the contrary, I have recently seen a case in consultation in which large quantities of albumen existed in the urine, but which disappeared almost entirely after the removal from the bladder of a calculus upon which the accompanying cystitis depended.

The *Prognosis* of chronic cystitis in relation to the life of the individual is nearly always favourable, except in those cases where the health has been broken down by previous disease, neglect, bad habits, want of proper food, old age, or other similar causes; or where the inflammation has reached and taken firm hold of the kidneys. In the last-mentioned condition death is inevitable after a longer or shorter interval. What I wish to say is that there is nothing in the disease itself which seriously compromises the life of the patient.

The question as to the curability of the affection is a totally different one, and can be answered satisfactorily only in reference to specified cases. I may state, however, in general terms, that where there is a fair condition of health, no serious disease of the kidneys or surrounding parts, little or no hypertrophy of the muscular coat of the bladder, and *the cause removable*, the prospect of recovery is very good.

Treatment. — It is scarcely necessary that I should tell you that in the treatment of chronic cystitis, as in that of a great many other surgical affections, the first indication is to remove the exciting cause. Fortunately, in a large number of cases, as for instance in those dependent upon the presence of calculus or other foreign substance in the bladder, of stricture of the urethra or of excessive alkalinity of the urine, this is entirely practicable, and

when it is accomplished the rapidity with which the morbid action subsides is sometimes truly astonishing. In calculus and phosphatic urine, nothing more is usually necessary, although it does occasionally happen, especially in old people, that the anatomical changes resulting from the long persistence of the inflammation continue to vex the patient long after the original source of trouble has been corrected. Where this is the case the special line of treatment which I am about to describe will frequently prove successful.

Resolution of the inflammation does not so often follow the dilatation of old stricture notwithstanding the fact that the bladder is thus enabled to empty itself completely. This is due principally to the hypertrophy of the muscular coat which has occurred in consequence of the accompanying tenesmus. Where such alteration has taken place, only palliation should be expected, and the patient may be obliged to wear a rubber urinal all the rest of his days. But as it is not always possible to determine in advance the existence of such a degree of hypertrophy, I make it a rule to subject all such patients to the curative treatment, trusting that some of these may thereby be materially benefited.

If the disease is dependent upon enlargement of the prostate gland as we so often see in old men, the state of affairs is in some respects like that met with in stricture of the urethra, with the difference that in the latter we have some expectation of getting rid of the producing cause, while in the former we have no such hope. Nevertheless by the daily introduction of a large-sized catheter, washing out the organ occasionally with some stimulating astringent, such as nitric, or better, hydrochloric acid, two drops to the ounce of water, and the internal administration of balsam copaiba, the inflammation may often be subdued. If these remedies should fail, the heroic treatment presently to be described should be resorted to.

And now I take pleasure in exhibiting to you again the patient, from ward 8, for the purpose of illustrating my further remarks.

This man, as you are aware, has been the subject of severe stricture of the urethra for several years, and presented, until very recently, all the symptoms of confirmed chronic cystitis. When I took charge of the ward, a few weeks ago, the stricture had been pretty well dilated by my predecessor, so that a No. 9 bougie could be slowly introduced by the patient himself, any undue haste inducing severe tenesmus. The symptoms of cystitis, however, had not much abated. His desire to urinate was incessant, and it was only by great effort accompanied by much suffering that he could restrain the evacuation for an hour at a time. While he was in bed he was compelled to keep a urinal between his thighs continually, otherwise he was not able to sleep for frequent necessity of rising. The urine, upon standing, as you have just now seen, separated into two parts, the upper tolerably clear, the lower opaque, thick, tenacious, yellowish in colour, and loaded with phosphates. Upon decanting the former, the latter, you noticed, clung in stringy masses to the bottom of the glass, and upon close inspection was found to consist of mucus and pus. Vesical tenesmus was not very frequent, although at times severe. Introduction of the finger into the rectum was productive of so much pain that the attempt to ascertain thus the thickness of the walls of the bladder was not satisfactory.

He was first put upon the use of copaiba and cubebs, which of all the internal remedies employed by surgeons in such cases hold deservedly, in my estimation, the highest place. In private practice I am in the habit of using an unofficinal preparation known as the compound extract of cubebs and copaiba, which is nothing more than solidified balsam combined with powdered cubebs and some other minor ingredients, and made into a paste which is not disagreeable to take. Of this a pill of 20 or 25 grains may be swallowed two or three times a day. In whatever manner the two remedies may be combined, they not unfrequently disturb the stomach and bowels, and require the addition of a little opium and tannin. The best time to take the remedy is about two hours after eating. The effect upon

the local symptoms is sometimes truly magical, and the patient passes in a few hours from a state of despondency to one of decided exhilaration in consequence of the great and sudden relief from painful micturition. By continuing these remedies for two or three weeks, employing at the same time a general tonic course if necessary, a cure may be sometimes produced, or, at any rate, such a degree of amelioration as to fully satisfy the expectations of the patient. I have sometimes thought that the addition of bicarbonate of potassa increased the efficacy of the medicine, but am not quite sure upon this point. I have not much confidence in uva ursi, notwithstanding it is so highly commended by my venerable private preceptor, Professor Gross, and still less in buchu. I have had no experience with cimicifuga, pareira brava, triticum repens, or matico.

If the copaiba and cubebs alone or in connection with the other means just enumerated should fail, as has happened in the case before us, local applications by injection are called for. For this purpose the following remedies may be employed in quantities sufficient to wash out the bladder thoroughly: nitric or hydrochloric acid (♏j to ℥j), liq. sodæ chlorinat. (♏x to ℥j), carbolic acid (grs. v to ℥j), tannic acid (℈ss to ℥j). I have tried all of these repeatedly, and a great many other washes, but except in very mild cases, and as an adjuvant to the cubebs and copaiba, have laid them aside. The remedy upon which I now rely almost exclusively is nitrate of silver in solutions of such strength as will make a decided impression upon the inflamed membrane. Those of you who are aware of the great caution advised by nearly all surgical writers and teachers in reference to the use of this salt as an injection into the bladder, and their timid recommendation of a solution not stronger than *half a grain to four ounces of fluid*,[1] have doubtless been somewhat startled when you have seen twenty grains, thirty grains, and forty grains to a single ounce of water thrown into the organ with impunity, and with decided benefit to the patient. It is now nearly twenty years since I recognized the absurdity of weak solutions, having remarked that they no sooner reached the bladder than they were immediately decomposed and thus rendered entirely inert by the few drops of urine which they are always sure to encounter there despite the most thorough irrigation and the most rapid change of apparatus. Aside from this, I could see no good reason why the mucous coat of the bladder should be an exception to all other similar structures, such, for instance, as the conjunctiva, the lining membrane of the fauces, the larynx, the trachea, and the uterus, to which surgeons are in the habit of applying not simply strong solutions but the solid salt itself. It seemed to me that it was only necessary to provide for the quick withdrawal of the fluid or its rapid decomposition, after allowing it to remain in contact with the inflamed surface for a few seconds, and no damage could occur from solutions even stronger than those already mentioned. After considering the question from this point of view, the first case that came into my hands was that of a young man, who several months previously had suffered paralysis of the lower half of the body, including the bladder, from spinal injury. The paraplegia had entirely disappeared, but the cystitis, which had resulted from neglected retention of urine, was unabated, and he had not the slightest control of the function of micturition, the water dribbling from him continually. After washing out the cavity thoroughly

[1] This is the strength of the solution recommended by Sir Henry Thompson, and repeated in nearly all the recent text-books on surgery. To prove its entire inefficiency I requested Mr. Johnson, the house chemist, to determine the relative incompatibility of urine and nitrate of silver, and he has shown by a number of experiments that 100 minims of the former of average quality will decompose 2.100 grs. of the latter. Now when it is borne in mind that urine enters the bladder ordinarily at the rate of 18 or 20 minims per minute, that this quantity is largely increased by the reflex action upon the kidneys induced by the passage of instruments along the urethra, that it is impossible to free the bladder entirely of urine even for an instant, and that a certain delay is necessary in making the injection, it seems to me no one can doubt, that the injection must meet with not less than 20 to 30 minims of urine which will decompose instantly not less than .700 of a grain of the salt.

I injected an ounce of a solution ℈ij to f℥j, permitted it to remain about ten seconds, and followed its withdrawal by an injection of a solution of iodide of potassium in order to decompose any of the former which failed to escape through the catheter. After a week or ten days sufficient improvement was manifested to justify a repetition of the operation. I then used the same quantity of a solution of the strength of ℥j to f℥j. The effect was all that could be desired. The symptoms improved within three or four days, and in less than a fortnight the patient returned to his home in Alabama entirely cured.

Before entering into further details, permit me to impress upon you two or three points of paramount importance in the use of this remedy. First of all *be sure that you are dealing with a case of genuine chronic cystitis.* Simulation of the disease, as already stated, is not uncommon in hysterical women, and irritation of the surrounding parts sometimes gives rise to symptoms which may mislead the unwary. Especially guard against the mistake of considering what is termed "irritable bladder" a condition of inflammation of the organ. You may rest assured, that, where a tolerably abundant discharge of vesical mucus is wanting, chronic cystitis does not exist. In the second place, be equally certain that the exciting cause has been removed, or at least so modified as to exert no further influence upon the disease. And, in the last place, never undertake this method of treatment unless the urethra is sufficiently large to readily admit a No. 9 or 10 catheter.

The only other instrument required besides a catheter of the size just mentioned is an elastic bag capable of holding one or two fluidounces, and provided with a bone or hard rubber nozzle well fitted to the former.

My custom is to begin with a 20 grain solution of the temperature of the body, using at least an ounce, so as to reach the entire surface of the interior of the organ. If no decided improvement should occur in the course of a week or ten days, the injection should be repeated, increasing the strength of the solution to thirty grains. No impression having been made by this last, the strength may be further increased, until a drachm to the ounce has been attained.

An important point to determine is the length of time the solution should be allowed to remain in the bladder. This must vary somewhat in different cases. If severe pain is instantly produced, two or three seconds is long enough for the first injection. If, on the contrary, the suffering is not considerable, eight or ten seconds may be allowed to elapse.

To remove the fluid it is only requisite to keep the nozzle of the bag closely pressed into the mouth of the catheter, and to relax the grasp of the hand upon the former. In this way nearly the whole of the fluid will be drawn back into the bag, and the remainder will readily escape by turning the patient upon his side.

We shall now proceed to perform the operation. The patient has been already injected once with a twenty grain solution about a fortnight since in the ward, and we propose to increase the strength now to thirty grains.

No anæsthetic will be given, for by doing so we should fail to obtain the information which we desire in regard to the sensitiveness of the organ when the injection reaches it.

You observe that the catheter is passed with some little difficulty, owing to the stricture which is not yet fully dilated, and that the urethra is very tender. Now that it is fairly in you see mucus and pus issuing from its mouth. By means of the rubber bag we next throw in an ounce or two of tepid water, and allow it to escape. In doing this, forcible distension of the organ should be studiously avoided. While the water is flowing out of the catheter the bag is filled with the solution, and as soon as all the water is forced out by pressure made with the hand above the pubes the nozzle is tightly pressed into the catheter, and the bag immediately, but not suddenly, compressed. The pain is not excessive, but as six or eight seconds have elapsed, pressure upon the bag is relaxed, and nearly all

the fluid is withdrawn. Upon squeezing it out into the bowl you notice that it has a very decided milky appearance, which is due to the partial decomposition which it has undergone in the bladder. Urine is constantly entering the cavity from the ureters, and, be as prompt as you may in the performance of the operation, a considerable portion of the nitrate is converted into chloride which is entirely inert. As already stated, I was formerly in the habit of following the injection by a solution of iodide of potassium, for the purpose of neutralizing the small quantity of the solution which is left behind, but this is entirely unnecessary, the urine which enters the organ proving quite as effective.

As you may readily suppose, the operation is followed by more or less tenesmus, and it is sometimes necessary to resort to a slight hypodermic injection of morphia, but ordinarily the pain subsides in the course of an hour or two, under the use of diluent drinks, aided, if necessary, by a warm hip-bath.[1]

As it is my desire to give you a perfectly ingenuous account of my experience in the use of strong solutions of nitrate of silver, I cannot bring this lecture to a close without calling your attention again to the man in ward 14, in whom these injections have been made without the slightest benefit, and upon whom, as a last resort, I performed the operation of cystotomy with no better success.

From the history of the case, written by the patient himself, it is evident that he suffered from chronic cystitis as far back as 1861, resulting from sunstroke and retention of urine. He had not entirely recovered from this in 1871, when he contracted gonorrhœa, and when nearly well, as he supposed, had retention of urine. An attempt was made to pass a catheter by a drunken doctor, who after severely lacerating the urethra abandoned the case to nature. The retention continued for thirty-two hours, when the patient passed into a delirious state, during which he does not know what occurred, and from which he recovered several weeks afterwards, to find himself unable to hold his water longer than a few moments at a time. Since then he has been treated by several physicians, some of them excellent practitioners, but without improvement.

He came into my hands a month or six weeks ago, apparently in good general health. The history of the case and the muco-purulent state of the urine afforded abundant evidence of the existence of chronic cystitis. Exploration with a metallic bougie showed that there was neither calculus of the bladder nor stricture of the urethra, but demonstrated excessive sensitiveness of the vesical mucous membrane, and probable columnar condition of the muscular coat. The bladder could not retain more than half an ounce of fluid without exciting severe tenesmus, and the patient was therefore compelled to wear a caoutchouc urinal. As the long duration of the case, the frequent tenesmus, and the evidence obtained by exploration rendered it more than probable that the hypertrophy of the muscular coat was considerable, I was unable to give the man any encouragement as to treatment. Nevertheless, as he was unwilling to return home without some attempt having been made to alleviate his distressing condition, and hoping that some benefit might possibly be conferred, I placed him upon the internal use of copaiba, cubebs, and belladonna, and injected his bladder in the usual way, three times, at intervals of a week, with the thirty grain solution. No good having been accomplished I suggested cystotomy, as a means of placing the bladder completely at rest for a given time, and permitting the further application of local remedies, but I explained that it would prove of no avail if the hypertrophy of the muscular coat should be found as great as I feared, and the extreme contraction of the bladder permanent. Like a drowning man, the patient grasped the slight hope that was thus held out, and in due time what is known as the lateral operation of lithotomy was

[1] The patient upon whom this operation was performed was so much improved that he left the hospital ten days afterwards in search of work. He has reported at my office once since then, and expressed himself as still doing well.

performed in your presence. Upon introducing my finger through the wound into the bladder my fears as to the condition of the muscular coat and the rigidly contracted state of the bladder were more than realized, as I then announced to you. As usual in such cases, there was considerable hemorrhage from the dilated veins around the neck of the bladder, and I was obliged therefore to keep the wound firmly plugged around a canula for five or six days. Two injections each of twenty grains of nitrate of silver were subsequently made through the wound, and the latter kept open for five or six weeks. Notwithstanding the free escape of the urine there was no relief from the vesical tenesmus except by large doses of morphia. The patient is now entirely well of the operation, but the condition of the bladder is unchanged, and will probably continue so indefinitely. In the mean time the man's general health is most excellent, better than it has been for several years.

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Summer Prurigo; Prurigo Æstivalis, seu Prurigo Adolescentium, seu Acne-Prurigo. By JONATHAN HUTCHINSON, F.R.C.S., Senior Surgeon to the London Hospital and to the Hospital for the Diseases of the Skin, etc.—(*Concluded from* p. 74.)

I will now read to you brief detached notes of some other cases which illustrate my assertions respecting this class of affections:—

A sugar refiner from Whitechapel, named Samuel H., was under care in July, 1870, for a pruriginous eruption on the legs, forearms, and face, which he said always got well in winter. There were a few vesicles mixed with the prurigo spots.

Mary A., a married woman, aged twenty-nine, suffered for a second time during the summer of 1870, from a pruriginous eruption on the arms, chest, thighs, and legs. It affected her face slightly. It has been well in the winter.

William H., a coke dealer, aged twenty-four, came under care in March, 1870, having then suffered from relapsing prurigo for six years. The eruption was to some extent eczematous, and although it affected the backs of the limbs most severely, the flexures were not quite exempt. He considered that it was worse in spring and autumn, but it never got quite well either in winter or summer. The skin of the lower extremities was rough and dry, and the eruption bore evidence of much scratching. His face was free when I saw him, but it had formerly been affected. The eruption, which was almost general, was only slight on the chest. He asserted that the little red spots, which were the first stage of the eruption, became white when rubbed. A sister and himself had suffered from "bad heads" in childhood, but in the interval he had been quite well, and his sister still remained so.

I cannot state the termination of this case. In some features it resembles a case of pruriginous eczema which I shall have to relate hereafter, in which, after several years of suffering, death occurred.

A girl named Sarah S , aged fourteen, under care in 1869, had a symmetrical papular eruption covering the face, arms, and hands. It was just like Charles P.'s, and was more severe on the face than elsewhere, and affected the backs of the arms more than the fronts. The itching was only slight. It was quite symmetrical, and had been present with summer relapses for three years. It was stated that two of her brothers older than herself had suffered from a similar rash for about the same time.

This history might suggest the probable existence of a parasitic cause, but the severity with which the face suffered seemed to negative this. After two months' attendance under treatment by arsenic and the lead and mercury ointment the notes state that she was nearly well.

Robert S., a harness maker, aged nineteen, attended at the hospital in August, 1869. His eruption was a prurigo, and was, he said, always worst in hot weather and almost well in winter. It occurred chiefly on the arms, but was present also on the trunk and outsides of thighs. He did not wear woollen next the skin. The notes do not state how long he had suffered, but imply a duration of several

years. We found pediculi on the head, but none in the clothes.

My next case is one of the longest duration which I have to mention, the patient having suffered for twenty years; still, however, it had not begun in infancy, and it was a summer rash, not a winter one.

Mary Ann W., aged thirty-three, a widow, applied in July, 1869. She had suffered from her eruption every summer since she was thirteen years of age. She was most positive as to the influence of season, asserting that she was always well in winter. She inherited gout, and had suffered from a single attack last winter. The eruption covered thickly the fronts and backs of the arms, backs of elbows, and backs of hands. There were some spots on the forehead, and a considerable number on the fronts of the thighs and legs. It did not occur at the flexures. The case differed from most others which I have seen, in that the face was but slightly affected. The woman described the itching as having been considerable at times, but the disease did not by any means appear to have embittered her life. She had been married and had borne children, and had never observed that the eruption was worse during pregnancy or lactation. She was stout, but not florid.

A girl named Jane B., aged twenty-two, was under care in September, 1869, for a copious eruption on the face, which had been much scratched, and which differed from acne in that the whole skin of the face was more or less inflamed, whilst there were no comedones and no pustules. My notes state that it was exactly like Charles P.'s case. She had a few spots on the backs of the hands, and had formerly had it on the legs also. She had been liable to the eruption on the face for five years, and had always been much worse in summer. A year previously she had been under care at Guy's. At the time of her application at Blackfriars, the eruption was complicated by urticaria, the wheals of which were as large as half-pence (possibly from bites). She took arsenic, and used a lead and mercury ointment, and in a month was "a good deal better."

The following case, although an example of severe and long-persistent prurigo, differs from Hebra's type in that the face was first affected and always suffered most severely, that the eruption got almost well in winter, and that it did not begin till the age of eight.

Harriet A., a milliner, aged seventeen, first came under our notice on June 25, 1869. She was then suffering from an eruption which affected the face, arms, and to a slight extent the chest, but from which other parts of the body were free. It was stated to have first appeared when she was eight years old, and to have then shown itself on the arms and face. Her face was now covered by an eruption in part papular and in part eczematous, and it was raw from scratching. On the arms the papules looked exactly like those of prurigo senilis (from lice). No wheals could be found, but she stated that the spots "began as bumps." There were no vesicles nor any papules which were free from evidences of scratching. Her mother spoke positively as to there having been no eruption in infancy or after vaccination. Two other older children and seven younger had remained free from skin disease. As a rule, it was asserted the skin would become quite clear in winter, but during the last winter she did not quite lose the eruption. My notes state that the eruption exactly resembled Charles P.'s. There were no spots on the fronts of elbows, but few on the fronts of arms, and not many on the shoulders. On the backs of the hands it came as low as the knuckles. We were told that on one occasion she was two months at the seaside and got quite well. Arsenic, in three-minim doses, was prescribed, and a lead and mercury ointment, and was continued with intermission for more than a year. My last note is July 21, 1871, that is, two years after her admission. She considered that she had on the whole been better for the treatment, but she had varied much, and had never been quite well on the face. When the arsenic was given in six-minim doses the eruption improved, but the remedy disagreed with her stomach. Tar lotions and the bismuth lotion had also been tried. The eruption

had always been at its worst in hot weather.

Catherine D., aged sixteen, came under care in June, 1871, with an eruption of "lichen prurigo," which affected her face, forehead, backs of forearms and arms, and front of chest. This was her second attack, and had lasted one month. Her first had occurred just a year ago, had lasted all the summer, and got well when the cold weather came. Her mother asserted that there had not been the least eruption in infancy or childhood. She attended until September, and took arsenic and used ointments. She was then much better, but not nearly well.

Mary H., aged twenty-two, has been liable to a relapsing pruriginous eruption for the last ten years. It comes out badly every spring and autumn, and when it leaves her, her skin becomes perfectly sound. The eruption resembles that of Charles P., but with a more decided tendency to urticaria, having sometimes "bumps or wheals as large as half-crowns." It affected chiefly the face and arms, but sometimes occurred on the back and chest and fronts of legs. Her first attack occurred very suddenly one summer, and came out freely. She remained under care from March 15, 1870, with intervals, till April 1, 1873, during which time she took arsenic, alkalies, quinine, etc., freely, and used a great variety of local applications. She was never wholly free from the rash for more than a week or two at a time, and there was no reason to believe that the arsenic did any good. She had taken it sometimes in six-minim doses, and her own impression was that it made the skin more irritable. She was always best in cold weather, and several times during winter her rash was reduced to a few isolated spots. The last note, on April 1, 1873, records her admission for a copious outbreak which had then lasted a fortnight, and states that she had been all but well. (I have no subsequent note.)

Eliza M., married, aged thirty-eight, has suffered from relapsing prurigo for five or six years. It affected the face, arms, body, and slightly the lower extremities. She had it first the first summer of her residence in London, and she states that she always gets rid of it if she goes into the country.

The following case supplies an example of Charles P.'s prurigo beginning on the face:—

Kate N., a girl aged eleven, admitted in May, 1869, had been subject to an eruption just like Charles P.'s for eighteen months. Her face was covered with papules, many of them scratched and capped by a blood-crust. It had itched much. It had never occurred in other parts than the face, and there it avoided the eyelids and was only sparingly developed in the forehead. It affected the ears, and the parts behind them. It was usually worse in hot weather. She was in good health, and there was no history of skin disease in her relations. She attended from May to July, and took arsenic, and used lead and mercury ointment, without any benefit.

I need not, gentlemen, trouble you with more cases. Those which I have quoted must, to those who have had patience to follow me, have sufficed to illustrate most of the assertions with which I commenced. You will, I think, sympathize with me in the difficulty in finding a suitable name. Although aggravated by heat and often quite well in winter, yet it is, as we have seen, by no means an exclusively summer malady. In its broad features, however, it contrasts strongly with winter prurigo, and thus the name suggested may be found appropriate, at any rate provisionally. You will see that we want more facts, that is, more completed cases—such cases, for instance, as that of Charles P.—extending over many years, and giving the final result. When these are collected, we may be able to give a more accurate description of the malady, and to find, perhaps, a better name. In the mean time we will beware of forcing our facts into any artificial uniformity. No two cases are exactly alike, and for the obvious reason that in all mixed causes are at work.—*Med. Times and Gaz.*, February 16, 1878.

HOSPITAL NOTES AND GLEANINGS.

Menstrual Fluid retained in the left Fallopian Tube, similating Ovarian Tumour; Abdominal Section during Acute Peritonitis.—Mr. Lawson Tait, Surgeon to the Birmingham Hospital for Women, records (*British Med. Journal*, May 11, 1878) the following interesting case:—

Miss M., aged 38, was sent to me in the beginning of 1877 by my friend Mr. Alfred Freer, of Stourbridge. In November, 1876, she had an ill-defined illness, during which she had obscure pelvic pains accompanied by fever. Previously to this illness, she had been in good health and had menstruated regularly. After it, she had severe pain during the whole period of menstruation, and she gradually increased in size until Mr. Freer discovered a pelvic tumour in February last. I found the tumour to be pear-shaped, quite movable, attached to the uterus at the left cornu, evidently unilocular, and about the size of an infant's head. I diagnosed it as a cyst of the parovarium, and advised that it should be tapped after it had increased in size sufficiently to warrant interference. She returned to me in May, with the tumour increased so as to be felt above the umbilicus. I advised her to come again in a month. She came, however, before the expiry of that period, on account of a sudden accession of serious symptoms; and when I saw her on June 20th, there could be no doubt she was suffering from peritonitis. Her pulse was 130; the temperature was 38.4 deg. C. (101.12 deg. Fahr.), and rose to 39.6 deg. C. (103.28 deg. Fahr.) in the evening; and there was excessive pain all over the abdomen, with considerable flatulent distension. I administered opium freely, and applied counter-irritation over the epigastrium.

On the morning of the 21st, she was easier, but the temperature of the pulse had not fallen. I therefore had her placed under the influence of ether by Dr. A. H. Carter, and proceeded to open the abdomen, assisted by Mr. Priestley Smith. The tissues of the abdominal walls were extremely vascular, and it was necessary to use a large number of ligatures to arrest the bleeding. The peritoneum was found to be intimately adherent to the tumour; and, as soon as the latter had been laid bare for a short distance, it became evident that it was not an ovarian tumour, but presented the red muscular appearance of the uterus. Passing the forefinger of my left hand down as deeply as I could in front of the tumour, with that of my right hand in the vagina, I made out distinctly enough that my original conception of the relations of the tumour to the uterus were perfectly correct. Under the suspicion that it might be a tubal pregnancy, I did not separate the tumour further, as I had not opened the peritoneal cavity, but cautiously opened the cyst in the middle line by means of a knife. As soon as I had reached its inner coat, I passed my small trocar in and evacuated about six quarts of thick dark-brown fluid, having the peculiar smell of menstrual fluid. After the cyst was emptied, I passed my finger through the hole made by the trocar; and to my amazement, I found that the cyst had contracted; and as I kept my finger in the cavity, I distinctly felt it contracting round and grasping my finger. Passing the finger of the other hand into the vagina, I made out that what I had opened was, beyond doubt, the left Fallopian tube, and that I must have opened it close to its fimbriated extremity. I could find no canal leading into the uterus, and did not deem it advisable to make one. I washed out the cavity freely with weak carbolic lotion, by reversing the siphon action of my trocar. The wound was closed by four deep sutures, one of which was so arranged as to fasten in a loop of wire drainage-tube; but before this was done, I acted on a hint from Mr. Priestley Smith and snipped off a piece of the cyst-wall for microscopic examination. This fragment proved to be composed of an abundance of unstripped muscular fibre, conclusively supporting the view that this singular tumour was a distended Fallopian tube. After the operation, I treated her exactly like a case of ovariotomy. Her temperature fell slowly. The wound suppurated freely, and shreds of what was undoubtedly mucous membrane came

away with the discharge in large quantity. The drainage-tube was removed on the twenty-first day, and its track continued to discharge till the beginning of August. It then healed, and she is now (October 18th, 1877) in perfect health, save that she has occasional pain in the wound. She has never menstruated since the operation.

From the fortunate issue of this case much is left to speculation, but of the nature of the tumour there is no doubt. As to its origin, it seems to me that it may be accounted for by the supposition that the illness from which all her symptoms dated was a localized salpingitis, which resulted in the closure of the two ends of the tube. The peritonitis, which she undoubtedly had when I operated on her, I suggest was due to a threatening rupture of the tube, and possibly a slight escape of its contents. If this be so, it is evident that it was only the accident of my determination to act promptly which saved the patient's life.

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Fracture of the Humerus by direct Muscular Action (Throwing a Cricket-Ball), no Displacement.—The great variety of cases of fracture of long bones which may be certainly attributable to direct muscular action has induced Mr. EDWARD BELLAMY, Surgeon to Charing-Cross Hospital, to place the following case on record (*Lancet*, May 11, 1878):—

"A short time since I was sent for into the country to see a lad fourteen years of age, who had an obscure injury to the upper arm. He was a well-made, muscular boy, fond of games, and on one occasion, when he had made a great effort in throwing a cricket-ball, he felt a sudden 'crack,' as he described, in his arm, which immediately fell useless to his side. I did not see the patient until some while after the accident happened, and from what I gathered, the fact of fracture could not have been so evident. On lifting the arm there was no bending to be noticed, and it was only by rotating the shaft of the humerus gently that I could detect that the bone was really broken. The seat of fracture lay a little below the insertion of the deltoid. If we analyze the several movements by which a ball would be set in motion by the combined action of the muscles called into play, the last act of all being a violent twist, if the ball be properly thrown, I cannot help thinking that it is possible to explain thereby an instance of the 'scraube-fractur' or screw-fracture, and which we may refer to mathematically under the condition of equilibrium in pairs or twists.

"There was slight lengthening, which was replaced by the rotation I mentioned, and which rotation both gave me crepitus and rendered the length of the humerus normal, as compared with the opposite arm.

"It is interesting to note that the fracture took place at or close to the 'deltoid" curve of the humerus, and, consequently, had it not been that the opposing surfaces of the bones were in such form of contact, as I must presume, any deviation must have been immediately recognized.

"The case is, at all events, excessively rare and suggestive."

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Typhoid Fever.—Dr. ALONZO CLARK, Professor of Pathology and Practical Medicine in the College of Physicians and Surgeons, New York, describes the treatment of typhoid fever as follows: Active treatment of this disease has been long abandoned. It used to be the fashion to bleed, and also to produce ptyalism. I remember doctors who said with confidence that where they saw evidence of the special action of mercury in these cases, they were sure of recovery. But all that has been abandoned.

Again, there were doctors, and perhaps there are some now, who put great confidence in a purgative plan of treatment; or, perhaps more strictly, an emetico-cathartic plan. An emetic and cathartic were administered together, and the cathartic was always calomel. It was claimed by those who resorted to this plan, that in certain cases abortion of the disease has been actually produced. I doubt that. In the course of an epidemic of

typhoid fever, cases of ephemeral fever occur. These terminate of themselves within a few days, and the general opinion now is that those cases which have been reported as aborted cases were really cases of ephemeral fever, or cases of themselves abortive. At all events, since "Graves fed fevers," the tendency in the profession has been to treat typhoid fever with as little medicine as possible.

I may safely say to you that a case of typhoid fever of average severity needs no medication except for the relief of certain symptoms, such as sleeplessness, perhaps a little urgency in the diarrhœa, sensation of burning upon the surface of the body, etc. There are a great many cases of typhoid fever which need no treatment whatever by way of drugs, but everything by way of management of the case. Still, it does happen in many of the cases that some one of the symptoms requires treatment. The *diarrhœa*, for example, in many cases requires restraint.

Diarrhœa does not occur in every case of typhoid fever in this country; perhaps it does not occur oftener than in two-thirds of the cases. But when it does occur, the usual remedies are serviceable here as in other forms of diarrhœa. The astringent which I have referred to so frequently is found to answer a very good purpose. It consists of—℞. Bismuth. subnit. ʒi., Morphiæ sulph. gr. i. M. et div. in chart. No. xii. One to four a day. The common astringents tr. kino and tr. catechu may be employed, and the decoction of blackberry root is sometimes very serviceable. In some cases it requires the moderately free use of opium to restrain the diarrhœa.

There is always a *cough* in typhoid fever, but as it is not important in the average case, I have not mentioned it until now. There is slight bronchial irritation, which appears early in the disease, and continues usually until the period of imperfect anæsthesia is reached, when it may cease. The material raised is commonly a glairy mucus, but in some cases the slight bronchitis becomes a catarrh, and will require treatment. It will need the treatment as bronchitis occurring under any other circumstances, except that the tonic expectorants will be most likely to do good. Perhaps one of the best that can be used is the *Co. Tr. of Benzoin*, in doses of ten drops on sugar once in three or four hours. A very good combination is the tincture of the balsam of tolu and the mistura guaiaci. ℞. Mist. guaiaci ʒj. to ℥ss., Tr. balsam tolu gtts. vj. to x. M. This can be repeated every two, three, or four hours. Sometimes the inhalation of the vapour of warm water seems to be required for one or two hours each day.

Restlessness is one of the prominent features of the disease, and that will very frequently be entirely quieted by sponging the surface of the body with warm or cold water. If the temperature is high cold water is better than warm; and in some cases a Dover's powder will be required.

The *temperature of the body* will require your attention. In many cases of typhoid fever it does not rise to a dangerous point; in a few cases it does. You will see the greater number of cases go through the entire course of the disease without the temperature at any time reaching 105° F. In a case of average severity the maximum temperature is about 104° F.; in occasional cases it reaches 106° F. or 107° F., and then you will either give quinine in pretty decided doses or use cold water for its reduction. If the patient is a young person, the cold bath is the most convenient means for reducing the temperature, and certainly the most efficacious. The temperature of the bath should be only ten degrees below the temperature of the body when the patient is first put into it. If the temperature of the body be 105° F., the patient may be placed in a bath having a temperature of 95° F.; then some of the warm water can be removed, and be replaced by cold water until the bath has been reduced to 80° F. If the patient is permitted to remain in such a bath twenty minutes, the temperature is usually reduced 1, 2, 3, 4, or even 5 degrees.

He is then removed from the bath, put back into bed, and it will be several hours, usually, before the temperature will rise as high as it was before using the bath. When it rises, another bath is to be given,

and in that manner you will go on repeating the bath as often as may be necessary to keep the temperature below the point of danger.

The son of one of the professors in this college has within the present session had typhoid fever. In his case the bath was used about five times a day for several days, and always with the result of reducing the temperature, and affording great relief to the patient.

For the *hemorrhage from the bowels* there is but little that can be done, unless, in addition to absolute rest, the fluid extract of ergot be administered.

For the *perforation of the bowels*, I have some faith in the opium treatment. As I told you, I feel confident that I saved one doctor's life by the narcotizing influence of opium, and there is no objection in typhoid fever to the administration of this drug.

"Graves fed fevers," typhoid fever as well as typhus; and now we come to the two essentials in the treatment of this disease. I am in the habit of repeating the old proverb, "Stuff a cold, and starve a fever," and then add that we stuff them both now. First, then, the administration, steadily and perseveringly, of such food as can be absorbed by the stomach. We cannot talk much of digestion; the stomach is in a diseased condition, and cannot digest well, consequently everything solid in the way of food is out of the question. Most of these patients dispose of milk pretty well. For all those who can dispose of it, milk is the best food that can be used. For those who cannot use it, you will be obliged to do the best you can with beef-tea, raw egg beaten up with water, and made of such consistency that it can be taken with a spoon, and the expressed juice of beef. The beef-tea does not contain a great deal of nourishment, and when it can be used, milk is a much better article of food.

The expressed juice of beef answers very well, and can be obtained by cooking a piece of steak so as just to crust the two surfaces, and then cutting it into pieces, and squeezing the juice out with a lemon-squeezer. The broths are given rather as diluted food in the early part of the disease, when it is supposed that the patient should not take much nourishment, but as the disease advances, the food should be more and more sustaining. In cases in which the stomach fails to retain food, nutritious enemata should be employed. You will remember that the disease which produces the diarrhœa, is in the small intestine, not in the large.—*Medical Record*, April 13, 1878.

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Medical and Chirurgical Faculty of Maryland.—The eightieth annual session of this body was held in Baltimore, on April 9, 10, and 11, 1878. Dr. A. B. Arnold, of Baltimore, President, in the chair. The following officers were elected for the ensuing year. President, Samuel P. Smith, M.D., of Cumberland; Vice-Presidents, Drs. J. C. Thomas and L. McLane Tiffany, of Baltimore; Secretary, W. G. Regester, M.D., of Baltimore.

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South Carolina State Medical Association.—The twenty-eighth annual session was convened at Greensville, on the 9th of April, Dr. J. F. M. Geddings, of Charleston, President, in the chair. The following officers were elected for the ensuing year: President, Dr. S. S. Marshall, of Greensville; Vice-Presidents, Drs. F. L. Parker, of Charleston; J. P. Du Bose, of Edgefield; J. J. Horton, of Kershaw; Secretary, Dr. A. S. Hydrick, of Orangeburg. The next meeting will be held at Charleston, on the second Tuesday in April, 1879.

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Georgia Medical Association.—This Association convened at Atlanta, on the 17th of April, under the Presidency of Dr. Wm. O'Daniel, of Twiggs County. The following officers were elected for the ensuing year: President, Dr. J. T. Johnson, of Atlanta; Vice-Presidents, Drs. W. F. Holt, of Macon, and T. H. Kenan, of Milledgeville; Secretary, Dr. James B. Baird, of Atlanta.

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Florida State Medical Association.—This Association convened in Jacksonville on 10th of April. The President's chair was draped in honour of the memory of Dr. F. P. Wellford, President elect. In the

absence of the Vice-Presidents, Dr. T. M. Palmer, of Monticello, was called to the chair. As a mark of respect to the memory of the late President, Dr. Wellford, the Association immediately adjourned until the afternoon. The following officers were elected for the ensuing year: President, Dr. R. D. Murray, of Key West; Vice-Presidents, Drs. A. L. Randolph, of Tallahassee, and C. W. Hersey, of Fernandina; Secretary, Dr. J. Y. Porter, of Key West.

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Alabama State Medical Association.—This Society met at Eufaula, on the 9th of April. Dr. Bryce, of Tuscaloosa, President, in the chair. The following officers were elected for the ensuing year: President, Dr. R. D. Webb, of Livingston; Vice-Presidents, Drs. T. D. Baker, of Eufaula, and K. C. Baldridge, of Huntsville; Secretary, T. A. Means, of Montgomery. The next meeting will be held in Selma, on the second Tuesday in April, 1879.

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Mississippi State Medical Association.—This Association met at Jackson, April 15, Dr. B. A. Vaughn, President, in the chair. The following officers were elected for the ensuing year: President, Dr. B. F. Kittrell, of Black Hawk; Vice-Presidents, Drs. R. G. Wharton, of Port Gibson, Hanslon, Vassar, of Carrollton, and Sale, of Aberdeen; Secretary, Dr. Wirt Johnson, of Jackson. The next meeting of the Association will be held at Aberdeen, in April, 1879.

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Texas State Medical Association.—The tenth annual session convened in San Antonio, on the 10th of April, Dr. W. D. Kelley, of Galveston, presiding. The following officers were elected for the ensuing year: President, George Cupples, M.D., of San Antonio; Vice-Presidents, Drs. J. W. White, of Waco, and W. E. Saunders, of Sherman.

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Tennessee State Medical Society.—The forty-fifth annual meeting of this Society was held at Memphis, on the 2d of April, Dr. B. W. Avent, President, in the chair. The following officers were elected for the ensuing year: President, R. F. Evans, M.D., of Shelbyville; Vice-Presidents, Drs. D. D. Saunders, of Memphis, H. J. Warmuth, of Rutherford Co., E. M. Wright, of Chattanooga; Secretary, Dr. J. B. Lindsley, of Nashville. The next meeting will be held at Nashville, on the 2d of April.

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Michigan State Medical Society.—The twelfth annual meeting of this Society was held at Lansing, May 15th and 16th, Dr. Foster Pratt, President, in the chair. The following amendment to the Constitution, offered last year, elicited earnest debate: "That no person shall be admitted to membership who practices or professes to practice in accordance with any so-called pathy or sectarian school of medicine, or who has recently graduated from a medical school whose professors teach, or assist in teaching, those who propose to graduate in or practice irregular medicine."

The object of this resolution was to exclude from membership graduates of the Michigan University, in whose medical department students of homœopathy are instructed. The amendment was defeated by a vote of 42 to 61. This ended the discussion, and the recent graduates who applied for admission and were reported upon favourably were elected.

The following officers and delegates were elected for the ensuing year: President, Dr. Edward Cox, of Battle Creek; Vice-Presidents, Drs. Whelan, of Hillsdale, J. R. Thomas, of Bay City, Banks, of Walled Lake, and Dunning, of Paw Paw; Secretary, Geo. E. Ranney, of Lansing. The Society adjourned to meet next year at Detroit.

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California State Medical Society.—The eighth annual session of this Society was held at San Jose, April 17, Dr. Washington Ayer, of San Francisco, President, in the chair. The following officers were elected for the ensuing year: President, Dr. H. S. Orme, of Los Angeles; Vice Presidents, Drs. A. W. Saxe, of Santa Clara, J. M. Briceland, of Shasta, James Simpson, of San Francisco, and G. L. Simmons, of Sacramento.

Illinois State Board of Health.—The Illinois State Board of Health has resolved that on and after July 1, 1878, it will not consider any medical school in good standing which holds two graduating courses in one year, and that it will not recognize the diplomas of any medical school which does not require of its candidates for graduation the actual attendance upon at least two full courses of lectures, with an interval of six months or more.

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Metric System of Weights and Measures.—In accordance with official orders, the medical officers of the Marine Hospital service will hereafter, for all official medical and pharmaceutical purposes, make use of the metric system. In expressing quantities by weight, the terms "gramme" and "centigramme" only will be used, and in expressing quantities by measure, the term "cubic centimetre." The metric system has already, under the Act of July 28, 1866, been adopted by this service for the purveying of medical supplies, and the weights and graduated measures, as well as the glassware hereafter furnished the medical officers, will be in accordance therewith.

FOREIGN INTELLIGENCE.

Cure of Chronic Albuminuria by Fuchsine.—M. Bouchut has been employing fuchsine at the Children's Hospital, Paris, in cases of chronic albuminuria, and appears to be well satisfied with the result of his experiments. The following observations, which we abridge, were appended to a case of albuminuria supervening on scarlatina, in a child six years old. M. Bouchut had already made some trials of fuchsine in similar cases; but, as he judiciously remarks, we must have a considerable number before we can establish the value of any remedy on a solid basis. We must bear in mind that recovery may depend on nature as well as on art. On the other hand, it should be remembered that although acute albuminuria, following scarlatina, diphtheria, or parturition, is often subdued in a few weeks, the chronic form of the complaint is very obstinate, and by some of our best authorities has been pronounced incurable. At all events, there is no remedy on which we can rely with anything approaching confidence. In the particular case now alluded to the albuminuria had succeeded scarlet fever ten months previous to the child's admission into hospital, and then became complicated by general anasarca. We have, therefore, the right to infer the existence of some serious organic disease affecting the parenchymatous tissue of the kidneys. The diminution of urea was also remarkable, yet there were no symptoms of uræmic poisoning. The improvement, besides, could hardly be attributed to the milk diet on which the patient was kept. The dose, it should be mentioned, was increased from one and a half to three grains of fuchsine daily, and the patient made a good recovery in the course of a fortnight.—*Medical Examiner*, April 25, 1878.

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Marino's Antineuralgic Injection.—Ergotine, one-fourth to one-fifth of a gramme; water or glycerine, q. s. Dissolve for a hypodermic injection. It is employed in neuralgic pains, and induces a more or less intense burning sensation, which disappears in the course of half an hour if the puncture be covered by cold wet compresses. Usually it induces neither abscess nor erysipelas. One or at most two injections relieve the pains, but in order to prevent relapses, from two to six others may be given, according to the intensity and duration of the neuralgia. In tic douloureux these injections have proved very useful, while in sciatica they have often failed.—*Union Med.*, April 18, and *Med. Times and Gaz.*, April 27, 1878.

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The Treatment of Cancer by Pressure.—M. Bouchut has recently introduced to the notice of the members of the Académie des Sciences a cuirasse of vulcanized caoutchouc, which he has used with success for the treatment of cancerous and other tumours of the breast. In this country there has been much division of opinion upon the utility of pressure in the treatment of cancer, some surgeons re-

garding it as harmful, or but rarely useful, others attributing to it great retardation of the rapidity of growth of the tumour, or even cure. The surgeons of Middlesex Hospital studied it systematically some years ago, and gave an unfavourable report. The theory of the plan is certainly good; a neoplasia, like a healthy tissue, is dependent upon its blood-supply for vitality and growth, and complete anæmia, causes the death of a tumour, as it does of a patch of brain-substance. It will be remembered that Mr. Haward last year related at the Clinical Society a case in point. He ligatured the left lingual artery for a recurrent epithelioma of the tongue; the tumour sloughed away, and a fortnight before the patient's death from blood-poisoning, the tongue was quite healed. In just the same way ischæmia will impair the vitality and so lessen the growth of a tumour. The difficulty is rather in the practical application of this theory. The knowledge that we now possess of the mode of growth of cancers gives us at least one important indication. If we have to deal with a neoplasia that grows at the periphery by gradual infiltration of the surrounding tissues, it is plain that, for pressure to be useful, it must be applied around the tumour rather than over it, where, by compressing and obstructing the capillaries, it would cause overfulness of those at the circumference. It is the periphery of a cancer that is its active part, and we must, therefore, produce ischæmia *around* and not *in* the tumour. In the application of the treatment this must be obtained by the careful adjustment of elastic pads of cotton-wool, and as the whole success of the plan depends upon the skill with which this is done, too much attention cannot be given to it. We cannot regard pressure as a substitute for removal of a cancer; but in the frequent cases where this is impracticable it appears to be the best substitute at present open to the surgeon. M. Bouchut's cuirasse would seem to be an improvement upon the spring pads and other appliances in use in this country.—*Lancet*, April 27, 1878.

Inflammation of the Bladder.—M. Guyon has always insisted on the propriety of distinguishing acute inflammation of the neck of the bladder from ordinary cystitis. Two cases recently observed at the Necker gave an opportunity of making some remarks on a method of treating the former affection by the direct application of nitrate of silver to the inflamed part of the bladder. For the last ten years M. Guyon has employed the nitrate in cases of this kind with very satisfactory results.

The inflammation is usually a sequence of severe gonorrhœa, but may have its immediate origin in various causes, such as violent exertion, venereal excesses, and, above all, indulgence in spirituous liquors. The principal symptoms are, as we can readily understand, chiefly connected with micturition. The patient is tormented by a constant desire to make water, and the last efforts to empty the bladder are attended by an extreme degree of vesical tenesmus; in severe cases a few drops of urine only come away at a time, and the fluid is usually tinged with blood, especially during the passage of the last drops. On examining the urine in the ordinary test-glass, we find a muco-purulent deposit at the bottom of the glass, and above this deposit a thin reddish-coloured web. In severe cases, however, the blood appears to be mixed with the whole contents of the glass, and the red web, now found at the bottom of the tube, is very clearly distinguished. The treatment of inflammation of the neck of the bladder hitherto employed differs little from that of acute cystitis, and is tedious. M. Guyon has replaced it by the application of a strong solution of lunar caustic immediately to the neck of the bladder. The instrument employed for this purpose is a syringe resembling that of Pravaz, and bearing a gum-elastic tube which terminates in a bulb. The latter must be of sufficient size to be felt in the regions of the scrotum and perineum. The tactile indications thus obtained are as distinct as if they were obtained from immediate applications of the finger. In the membranous portion of the urethra the olivary bulb is moderately compressed;

in the prostatic region the pressure is somewhat increased; while entrance into the bladder is at once indicated by its freedom of motion. But to insure the certainty of this latter indication a good-sized bulb is required, otherwise the injection may be made *in* the bladder, and *not in* its neck,—an error which has occurred on some occasions. Having arrived at the neck of the bladder the surgeon employs gentle pressure on the extremity of the syringe, each stroke of which is attended by the instillation of a drop or two of its contents. The fluid excites very little pain in this portion of the urethra, and may be applied to the extent of twenty to thirty drops at a time. M. Guyon insists on the necessity of proceeding slowly, and with great care, otherwise we may bring on spasm in the membranous portion of the urethra and immediate expulsion of the injection. In nearly all cases the patient experiences some uneasiness or even pain for an hour or two after the instillation; this, however, is confined to the moment of evacuating the bladder, and in a few days the injection ceases to excite any pain worth speaking of; micturition is now less frequent, and the urine passed is free from blood.

The duration of treatment by this method is stated to be comparatively short, seldom exceeding more than seven or eight days. The solution employed by M. Guyon contains one grain of nitrate of silver to fifty parts of water.—*Medical Examiner*, May 9, 1878.

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Ointment in Gonorrhœal Orchitis.—Dr. Alvaréz recommends (*Union Méd.*, April 16) the following pomade: Finely powdered iodoform, one to two parts; lard, thirty parts. In the course of an hour or two, he says, the pain is relieved. It has also the advantage over the mercurial ointment of not affecting the gums. By its well-known resolvent action the iodoform diminishes the duration of the orchitis, and prevents subsequent induration of the affected organ. It must be used more or less strong, according to the degree of inflammation of the epididymis existing.—*Med. Times and Gaz.*, April 27, 1878.

Prevention of Puerperal Fever.—The sanitary authorities of the Tyrol have recently published a regulation to the following effect with regard to the prevention of puerperal fever. After declaring that the disease in question is of an infectious nature, and may be conveyed from one patient to another by means of instruments, sponges, or the hands of the attendant, the regulation enjoins that all instruments which have been used, even for a healthy patient, before, during, or after delivery, shall be afterwards thoroughly washed in a solution of carbolic acid. Before examining a patient, the midwife is also to take the same precaution with regard to her hands. In order that the disinfectant shall always be forthcoming, every midwife must, under a penalty, when called to a lying-in woman, take with her a concentrated (five per cent.) solution of carbolic acid. When required for use, one part of this solution is to be mixed with four parts of water.—*Medical Examiner*, April 25, 1878.

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Arterial Degeneration and Vegetable Diet.—Prof. Gubler, in his recent researches as to the causes of cretaceous degeneration of the arteries, has made the very interesting discovery that a principal cause lies in a vegetable diet, and thus explains the frequency of cretaceous arteries among the French rural population at the early age of forty. This is the more important because it is well understood that "a man is as old as his arteries," and that chalky degeneration of the arteries is the most fatal kind of premature senility. Further proof he finds in the fact that the Trappists, who live exclusively on vegetable food, very soon show arterial degeneration. In districts where chalky soils load the drinking-water with earthy salts, a vegetable diet acts more rapidly in affecting the arteries than in regions of siliceous formation.—*British Med. Journal*, April 27, 1878.

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Sewer-Communications and Filth-Diseases.—Dr. James B. Russell, the Medical Officer of Health for Glasgow, in a paper recently read before the Philosophical So-

ciety of Glasgow, has made a valuable contribution to our knowledge of the effect of sewer-gas upon the production of enteric fever and diphtheria, two of the most clearly defined filth-diseases. It appears that, since 1873, every fatal case of any zymotic disease or of lung-disease in Glasgow has been entered on a card, upon which has also been recorded, after inquiry, "minute details about the size of the house, the position of the water-closet if there be one, and also of the ashbox or sink." During the three-and-a-half years ending December last, 420 fatal cases of diphtheria and 833 of enteric fever have been dealt with in Glasgow on this detailed card system, and form the basis of Dr. Russell's investigation undertaken with a view to calculate the effect of sewer-communication in the production of these diseases. For this purpose, the houses in which these deaths from enteric fever and diphtheria were recorded were divided into four classes: (1) those having a water-closet inside, with or without a sink; (2) those having a sink inside, but no water-closet; (3) those having no connection whatever between their internal atmosphere and the sewers—that is, having neither water-closet nor sink; (4) and those concerning which, from the addresses not being found or other causes, the information was not obtained. The investigation, for reasons which it is here unnecessary to dwell upon, was confined, so far as it deals with the influence of sewer-gas, to houses of one and of two apartments. The total number of houses of each size in the city was obtained from the City Assessor's annual assessment-roll; and the proportion of the houses of each of the four classes above mentioned was determined from a return called for by Dr. Fergus in 1872, showing the numbers and the class of the houses having water-closets, drains, etc., in communication with the sewers. In order to ascertain the number of persons living in these houses of different sizes, Dr. Russell assumed that the average number of inmates of the houses in each class prevailing at the census in 1871 is still maintained. It may be stated that, in one way or other, the internal atmosphere of fully 33 per cent. of the one-apartment and 69 per cent. of the two-apartment houses was in communication with the sewers.

Dr. Russell set himself to answer the following questions: Does it make any difference to the inhabitants of a one- or two-apartment house, whether there is or is not a communication between the house-air and the sewers? Are the residents of these houses, or are they not, more liable to be fertilized with the germs of these two special filth-diseases? The number of houses of one apartment having an internal water-closet was too small to afford a trustworthy basis for calculation; but, among those persons living in houses of one apartment having no communication with the sewers, the death-rate per million was equal to 120 from diphtheria, and to 249 from enteric fever; whereas, among the residents of one-apartment houses containing a sink-communication with the sewer, the rate from diphtheria was equal to 253, and from enteric fever to 677, per million. So, in the houses of two apartments having "no direct means of access for the specific germs," the rate from diphtheria was 127, and from enteric fever 386, per million; in those having a sink, the rates became 275 and 465; while in those having an inside water-closet in addition to the sink, the death-rate from diphtheria rose to 418, and from enteric fever to 665, per million. Thus it seems to be proved that in Glasgow, during these three years and a half, the lowest death-rates from diphtheria and enteric fever occurred in those houses of one and of two apartments having no communication with the sewers; while the highest rates were found in those houses of two apartments which were provided both with water-closets and sinks. The mortality from each of these diseases was, however, found to be still higher in houses of three apartments; but, as the proportion of this class of houses provided with sewer-communications is unknown to Dr. Russell, he was unable to deal with their statistics so completely as he did with those of one and two apartments. As, however, the pro-

portion of internal sewer-communications rose from 83 per cent. in the houses of one apartment to 69 per cent. in houses of two apartments, it is only reasonable to assume that three and four apartment houses are still more fully provided with internal sewer-communications. Hence, probably, the still higher death-rate from these diseases, the specific germs of which conclusively appear to be distributed by sewer-gas. Dr. Russell expresses his conviction, which is fully warranted by his carefully compiled statistics, that it is the absence of the sewer-connection by sink and water-closet with the internal atmosphere of a large proportion of the one- and two-apartment houses which causes the death-rates from diphtheria and enteric fever to be lower in these than in larger houses. He further says: "If every house of each size were connected alike with the drains and sewers, then I am sure the diseases specially associated with such misplaced connections would conform to the general law of other diseases, and be at their maximum in the smallest houses."

Dr. Russell concludes his valuable paper by stating that, if we would reduce the mortality from diphtheria and enteric fever to the "lowest possible minimum," not only must all internal communications with the sewers be as far as possible abolished, but our sewers and house-drains must be ventilated on the separate system, and the use of cistern-water for dietetic purposes must be entirely discontinued. There is no reason to doubt that what Dr. Russell has proved with regard to the mortality from diphtheria and enteric fever in Glasgow is more or less true with regard to their mortality in other sewered towns. It is, however, to be feared that but few medical officers of health have provided themselves with the materials for so valuable an investigation as that which has been so carefully elaborated by the indefatigable Medical Officer of Health for Glasgow.—*British Med. Journal*, May 11, 1878.

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Treatment of Wounds of the Hand.—Prof. VERNEUIL (*Gaz. des Hôp.*, March 20th), on the occasion of operating on a patient who had been admitted three months before for a crushed hand, repeated to his class an emphatic injunction which he has often delivered before. Whenever, he said, you have to treat any kind of crushed wound of the hand, take it as an absolute rule to excise nothing and to regularize nothing by means of the bistoury. In these cases the surgeon should only seek to prevent and to combat the primary accidents, leaving to Nature the care of saving all she can save. She will preserve more than the surgeon could, and will always diminish the mischief. One can hardly conceive the extent to which lacerated tissues, seemingly condemned on the first day, will resume their vitality and undergo reparation. Let Nature alone, then, and wait. At a later period, after weeks or even months, when cicatrization has taken place, then only can the surgeon interfere and regularize the wound so as to render the use of his limb more easy to the patient. After describing the procedures he would have to take in order to regularize the cicatrized wound in this case, Prof. Verneuil observed that had he been tempted to interfere on the first day, some months since, he should have removed parts which can now be made useful, while the patient has passed through the intervening time favourably by the aid first of simple and then of antiseptic dressings. He contrasted the progress of this case with that of another in which, before sending the patient to the hospital, his surgeon performed some partial amputations, which were followed by phlegmon of the forearm, arthritis, and suppuration of the carpus, etc. The case demonstrates the immense difference there exists between operations performed on the hand during the acute period of the accident, and operations executed later during a condition of absolute quietude of the region. Such cases are met with daily, and the practitioner ought to have a very clear opinion and pursue a practice rigorously determined upon, never employing the bistoury in a recent wound of the hand, and never regularizing the wound until two or three months after the accident.—*Med. Times and Gaz.*, April 6, 1878.

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